CONFIDENTIAL PATIENT CASE HISTORY AND ACCIDENT QUESTIONNAIRE

DE BRUIN CHIROPRACTIC, LTD.
8010 East McDowell Road, Suite 123
Scottsdale, AZ 85257
Phone 480.946.4476 Fax 480.946.3024

Date: _____

Patient Name: _____ Date of Birth: _____ Age:_____

Address: _____Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Cell Phone _____Home Phone _____Work Phone _____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation: _____Employer: _____

Spouse's Name: _____Spouse's Employer: _____

In case of emergency, notify_____ Relationship: _____ Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*❑ Primary Phone❑ Secondary Phone❑ Mobile Phone❑ Home Email❑ Work Email

Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet?	❑ In what city were you born?	❑ What high school did you attend?
❑ What is your favorite movie?	❑ What is your mother's maiden name?	❑ On what street did you grow up?
❑ What was the make of your first car?	❑ When is your anniversary?	

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

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Current Symptoms: 1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

7 _____ 8 _____ 9 _____

When did your symptoms begin? _____

In general, what makes your symptoms better? _____

In general, what makes your symptoms worse? _____

In general, how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ *Jaw Pain (TMJ)*	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

_____

Please list all medications and dosage: Frequency For What Illness?

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____
Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all SURGERIES: Date

_____

_____

_____

Please list any recent x-rays, lab or other tests: Date Facility/Doctor

_____

_____

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Date of Crash/Accident: _____ Hour: _____ ☐ AM ☐ PM

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____

Specific Location of Crash/Accident: _____

Describe in detail, in your own words, how the crash/accident happened: _____

_____

_____

_____

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Vehicle was driven by: _____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side Were you aware of impending crash?: ☐ Yes ☐ No

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No Did accident occur on ☐ public or ☐ private property

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, describe _____

Did anything inside the vehicle strike you? ☐ Yes ☐ No If yes, describe _____

Did your vehicle hit any other object after the crash? ☐ Yes ☐ No If yes, describe _____

Were you wearing a hat, eyeglasses or sunglasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Estimated damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: _____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Your Vehicle (Year, Make, Model): _____

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) _____

Head restraints: ☐ None ☐ Integral Type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know

Was the head restraint position altered by the accident? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

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Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: _____ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

To which hospital? _____ Date of Hospitalization: _____

Address: _____

Were you seen in the Emergency Room?: ☐ Yes ☐ No Were taken by ambulance? ☐ Yes ☐ No

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed _____

Results of X-rays: _____ Lab work: ☐ Yes ☐ No Results: _____

Cervical collar ☐Yes ☐No Ice: ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of medication: _____

Other treatment: _____ Follow-up Instructions: _____

Work restriction ☐ Yes ☐ No If yes, describe_____

Other Doctor You Might Have Seen For Treatment Since Crash (#1):

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Other Doctor You Might Have Seen For Treatment Since Crash (#2):

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Treatment by Another Chiropractor: _____ Dates: _____

Have you done any of the following since the crash/accident?

☐ Ice ☐ Medication (name) _____ ☐ Rest
☐ Heat (any kind) ☐ Exercise ☐ Other_____

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DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

**Please answer the following questions the best that you can. This helps to understand what Activities of Daily Living you are able to perform or not perform.*

	Circle Appropriate Answer			*Comments*
Can you sit in office chair?	Yes	No	Difficult	
Can you stand upright?	Yes	No	Difficult	
Can you climb steps / stairs?	Yes	No	Difficult	
Can you stoop over to pick something up?	Yes	No	Difficult	
Can you crouch down to pick something up?	Yes	No	Difficult	
Can you kneel down?	Yes	No	Difficult	
Can you reach overhead?	Yes	No	Difficult	
Can you lift from waist to shoulder height?	Yes	No	Difficult	
Can you carry an object 100 feet?	Yes	No	Difficult	
Can you push something?	Yes	No	Difficult	
Can you pull something?	Yes	No	Difficult	
Are you having balance issues?	Yes	No	Difficult	
Are you able to crawl?	Yes	No	Difficult	
Can you reach straight out and overhead?	Yes	No	Difficult	
Can you handle objects appropriately?	Yes	No	Difficult	
Finger/Hand strength/coordination?	Yes	No	Difficult	

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The following is a list of various symptoms and conditions. It is important to know problems that you are having form the accident and issues you have had before the accident. If you do not have a particular problem, just leave it blank. If you have had the issue *since the accident* put an **"A"** on the line. If you have had the issue *before the accident* put a **"B"** on the line.

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

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PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____Telephone: (_____) _____Insured: _____

Claim #: _____Policy #: _____

Claim Representative: _____

Telephone: _____Ext:_____ Fax: _____

Med-Pay Benefits: _____ ___Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____Policy #: _____ SS#: _____

Telephone: _____ Fax: _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____Policy #: _____Insured: _____

Telephone: _____Fax: _____

4) ATTORNEY: _____Legal Assistant: _____

Address: _____

Telephone: _____ Fax: _____

HIPAA Compliance
Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient's Signature: _____ Date _____

Witness: _____Date: _____

I hereby affirm that the above information is complete and accurate to the best of my knowledge. Furthermore, I hereby consent to any necessary and reasonable treatment for the conditions(s) for which I have sought treatment. I also understand that I have the right and duty to ask my doctor to explain further anything in connection with my condition, care, or treatment that I do not understand.

Patient's Signature: _____ Date _____

I hereby affirm that I am the appropriate individual to authorize care on behalf of _____ and that I hereby agree to the above on his/her behalf.

Guardian or Spouse's
Signature Authorizing Care _____ Date _____